Discontinue Dependent Coverage

King County
Benefits, Payroll and Retirement Operations

- Submit this form within 30 days after the qualifying event (or sooner) to Benefits, Payroll and Retirement Operations, The Chinook Building CNK-ES-0240, 401 Fifth Ave., Seattle 98104-2333, or fax it to 206-296-7700.
- Submit one form for each dependent.
- If you would like to discontinue coverage for a dependent from some, but not all, benefit coverage (for example, delete them from health coverage but not life insurance coverage, if they remain eligible), be sure to indicate the specific coverage you would like to discontinue. Otherwise, we will discontinue all coverage for your dependent.
- If you delete a dependent because you and your spouse have separated or are planning to divorce, they will not be eligible to continue their health benefits under COBRA—they will only be eligible for COBRA at the time a divorce is final. When a divorce is final, you must notify Benefit, Payroll and Retirement Operations within 30 days after the date of the divorce.
- You might also want to submit new county insurance, state retirement and deferred compensation beneficiary designation forms.
- Questions? Go to www.kingcounty.gov/employees/benefits, e-mail kc.benefits@kingcounty.gov or call 206-684-1556.

Provide information about the dependent for whom you're discontinuing coverage

Event prompting change
- ☐ Death
- ☐ Divorce
- ☐ Domestic partnership ended
- ☐ Separation (you must notify Benefits, Payroll and Retirement operations when a divorce is final)
- ☐ Qualified Medical Child Support Order ended (attach copy)
- ☐ I self-pay to cover this family member and opt not to continue
- ☐ Child no longer eligible
- ☐ Other(explain) _____

Date event occurred _____

Dependent name _____ Birth date _____

Mailing address for COBRA notification (required if dependent is living at a different address than yours)

Street _____ Apt No _____

City _____ State _____ ZIP _____

Coverage you would like to discontinue

Please indicate the coverage you would like to discontinue for the dependent listed above. If you do not indicate specific coverage, we will discontinue all coverage for the dependent listed above.

☐ I would like to discontinue all coverage for the dependent listed above.

I would like to discontinue only the following coverage for the dependent listed above:

- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ Supplemental life
- ☐ Supplemental accidental death and dismemberment (AD&D)

Authorize your change

This information is true, correct and complete, and amends previously submitted information. I authorize King County to make any payroll deductions or refunds resulting from my requested change. I understand the willful falsification of any information I have provided may lead to disciplinary action up to and including discharge from employment.

Employee signature _____ Date signed _____

Printed name _____ Contact phone (_____)_____

Paid ☐ 5th and 20th ea month ☐ Every other Thursday Employee ID _____

Office use only	Date received	Processed by	Audited by	Date effective